Virginia Department of Medical Assistance Services

837 Dental Encounters
Data Clarification
for
Doral Dental

ASC X12N 837
Version 004010X097A1

Version 1.0
March 22, 2006

Version Change Summary

Version No.	Description	Date
Version 1.0	Original Implementation	03/22/2006

INTRODUCTION

This document is a companion to the National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Dental, ASC X12N 837 dated May 2000 (IG) and the Addenda dated October 2002 (004010X097A1). The 837 IG and Addenda are available from the Washington Publishing Company and may be downloaded from www.wpc-edi.com/hipaa/.

DMAS intends that this clarification document be used in conjunction with the IG and Addenda, which contain all of the Health Insurance Portability and Accountability Act (HIPAA) transaction and code set requirements. This document supplements the IG and Addenda with data clarifications that are authorized under HIPAA. It is provided to clarify situations where the IG is not specific and to help the contracted Dental vendor understand how DMAS will be using the inbound 837 transactions and its data elements in the Virginia Medicaid Management Information System (VaMMIS).

PURPOSE

The purpose of this clarification is to outline DMAS's specific requirements with respect to the 837 data loops, segments, and elements for encounters reported by the Dental vendor. The goal is to facilitate the contracted Dental vendor's understanding of DMAS's data needs.

Dental claims and encounter data submitted to DMAS using the 837 transactions should follow the Provider-to-Provider-to-Payer COB data model referenced in the IG (see page 15 of the guide for information about this model). This model contains loops, segments, and data elements that provide information necessary for DMAS's MMIS and decision support systems.

Page numbers on the following data-clarification matrix refer to the page number in the IG on which the data element appears. Page numbers that begin with "A" are Addenda page numbers. Page numbers that begin with "B" are from Appendix B of the IG, EDI Control Directory.

All data elements that are used by the VaMMIS are listed on the following matrix. The matrix does **not** include all data elements that are required by the IG and those must be coded according to instructions in the IG. The instructions here are not intended to override instructions or requirements contained in the IG; they are provided to clarify DMAS's expectations with respect to the various data elements within the 837 transaction where interpretation is possible.

Not all data elements that are indicated as used on the following matrix are required in every situation. Some of the data elements indicated as used are required only when a specific situation is present. For example, Hospital Admission Date is required only on services that are related to a hospital admission.

If the Dental vendor sends any claims that are not covered under its contract with DMAS, those claims must be send in a separate ISA-IEA envelope. They should not be mixed with the encounter data the vendor is reporting for services rendered under contract with DMAS.

REQUIRED ENCOUNTER DATA

All encounters processed by the MCO or any MCO subcontracted vendor should be submitted to DMAS in the prescribed format, including records that were denied for most reasons.

The exceptions, which should NOT be submitted to DMAS, are:

- Encounters that are rejected by the MCO
- Encounters that are duplicates of records previously submitted by the provider
- Encounters that contain an invalid Medicaid recipient identifier
- Encounters for Medicaid recipients who are not enrolled with your MCO

If the encounter being submitted is one that you have denied, the encounter should be submitted to DMAS with the appropriate denial reason code from the Adjustment Reason Code set (code source 139) appearing in the first CAS segment of the encounter.

ADJUSTMENTS and VOIDS

When submitting adjustment or void records, please ensure the adjusted or void record conform to the following requirements:

1. If the record to which the adjustment applies was not previously submitted to VaMMIS, the original record must precede the adjustment record in the file containing the adjustment record. In other words, you can submit an original and adjustment record in the same file as long as the original record precedes the adjustment record.

2. Your claim number on the original record must be coded in Loop 2300, REF segment (page 180 of IG), REF02 – Original Reference Number. If this number does not match a number in the DMAS system, the adjustment or void record will be assigned a fatal error code.

3. If you are adjusting or voiding one service line on a claim that has more than one line, you must adjust or void all lines. The order in which the service lines appear on an adjusted or voided claim must be the same as on the original claim.

NATIONAL PROVIDER IDENTIFIER

The final rule on National Provider Identifiers (NPI) becomes effective on May 23, 2007 (except for small health plans, which have until May 23, 2008). The final rule specifies that a covered provider must use its assigned NPI where called for on all HIPAA-

specified electronic transactions exchanged between covered entities beginning on May 23, 2007 (or May 23, 2008 for small plans).

In order to prepare for compliance with the NPI rule, DMAS will implement its use of the NPI in phases as follows:

Phase 1: Effective immediately, DMAS will accept both legacy ID (current nine-digit Medicaid provider ID) and the NPI but only the legacy number will be used in the VaMMIS.

Phase 2: Effective 2/17/2007 DMAS will accept both the legacy ID and the NPI. However, if an NPI is present, only the NPI number will be used.

Phase 3: Effective 5/23/2007, DMAS will only accept the NPI. Legacy IDs will be returned as invalid.

For providers that are not considered health care providers and cannot obtain an NPI (such as taxi drivers), DMAS is developing a plan to provide those providers with a ten-digit ID that will mimic the NPI.

DMAS DOCUMENTATION

To further assist MCOs in the encounter data submission process, DMAS is providing other information that MCOs should review. These documents include:

- Encounter Data Submission Manual at https://virginia.fhsc.com/providers/Manuals.asp
- Companion Guides at https://virginia.fhsc.com/hipaa/CompanionGuides.asp
- Data Clarifications at http://www.dmas.virginia.gov/mc-encounter.htm

The Companion Guides are not specific to encounter data, but may contain helpful information not found in the Data Clarifications or this Encounter Data Submission Manual.

Data Clarification – 837 Dental Transaction
for
Doral Dental

Page	Loop	Segment	Data Element	Clarification
B.3		ISA	ISA01 – Authorization Information Qualifier	Use “00”
B.3		ISA	ISA02 – Authorization Information	Use ten blanks
B.4		ISA	ISA03 – Security Information Qualifier	Use “00”
B.4		ISA	ISA04 – Security Information	Use ten blanks
B.4		ISA	ISA05 – Interchange ID Qualifier	Use “ZZ”
B.4		ISA	ISA06 – Interchange Sender ID	Use 1076
B.4		ISA	ISA07 – Interchange ID Qualifier	Use “ZZ”
B.5		ISA	ISA08 – Interchange Receiver ID	Use “VMAP FHSC FA”
B.5		ISA	ISA09 – Interchange Date	YYMMDD of interchange
B.5		ISA	ISA10 – Interchange Time	HHMM of interchange
B.5		ISA	ISA11 – Interchange Control Standards Identifier	Use “U”
B.5		ISA	ISA12 – Interchange Control Version Number	Use “00401”
B.5		ISA	ISA13 – Interchange Control Number	Nine-digit control number assigned by sender. Must match the value in IEA02.

Page	Loop	Segment	Data Element	Clarification
B.6		ISA	ISA14 – Acknowledgment Requested	Use “0”
B.6		ISA	ISA15 – Usage Indicator	Use “P” for production data or “T” for test data
B.6		ISA	ISA16 – Component Element Separator	Use “>”
B.8		GS	GS01 – Functional Identifier Code	Use “HC”
B.8		GS	GS02 – Application Sender’s Code	Use “1076” for Doral Dental
B.8		GS	GS03 – Application Receiver’s Code	Use “VMAP FHSC FA”
B.8		GS	GS04 – Functional Group Creation Date	CCYYMMDD
B.8		GS	GS05 – Creation Time	HHMM
B.9		GS	GS06 – Group Control Number	Assigned by Doral Dental. Must be identical to the associated functional group trailer, GE02.
B.9		GS	GS07 – Responsible Agency Code	Use “X”
B.9		GS	GS08 – Version/Release/ Industry Identifier Code	Use “004010X097A1”
53		ST	ST01 – Transaction Set Identifier Code	Use “837”
54		ST	ST02 – Transaction Set Control Number	Use a number that is unique within the functional group and interchange (GS-GE and ISA-IEA). Must be identical to SE02.
54		BHT	BHT01 – Hierarchical Structure Code	Use “0019”
55		BHT	BHT02 – Transaction Set Purpose Code	Use “00” if original submission; use “18’ if the file is being resubmitted.

Page	Loop	Segment	Data Element	Clarification
55		BHT	BHT03 – Originator Application Transaction Identifier	Specific to Doral Dental – this will operate as the batch control number.
55		BHT	BHT04 – Creation Date	CCYYMMDD
56		BHT	BHT05 – Creation Time	HHMM
56		BHT	BHT06 - Transaction Type Code	Use “RP” (Reporting or encounter)
A11		REF	REF01 – Reference ID Qualifier	Use “87”
A11		REF	REF02 – Transmission Type Code	Use “004010X097A1”
61	1000A	NM1	NM109 – Submitter Primary Identifier	Use “1076” for Doral Dental
67	1000B	NM1	NM103 – Last Name or Organization Name	Use “Dept of Med Assist Svcs”
67	1000B	NM1	NM109 – Receiver Primary ID Code	Use “Dept of Med Assist Svcs”
78	2010AA	NM1	NM108 – Identification Code Qualifier	After implementation of the NPI, use “XX”, until then use either: 24 = Employer’s Identification Number 34 = Social Security Number
78	2010AA	NM1	NM109 – Billing Provider ID	If NM108 is XX, this is the NPI for the provider that is billing for the service (not Doral Dental’s ID). Prior to NPI implementation, use the provider’s (not Doral Dental’s) identifier as indicated above.
84	2010AA	REF	REF01 – Reference ID Qualifier	“1D” (Medicaid Provider Number). This segment will not be needed after full implementation of the NPI. In its place the NM1 segment will be used to report the billing provider NPI.
84	2010AA	REF	REF02 – Billing Provider Secondary ID	This is the nine-digit Medicaid ID number of the billing provider. This segment will not be needed after full implementation of the NPI.

Page	Loop	Segment	Data Element	Clarification
96	2000B	HL	None	The number of claims within an ST/SE segment is limited to 5,000 as recommended in the IG.
99	2000B	SBR	SBR01 – Payer Responsibility Sequence Number Code	Use “S” (Secondary) or “T” (Tertiary)
104	2010BA	NM1	NM103 – Subscriber’s Last Name	Report the last name of the subscriber
104	2010BA	NM1	NM104 – Subscriber’s First Name	Report the first name of the subscriber
105	2010BA	NM1	NM108 – Subscriber ID Qualifier	Use “MI” (Member Identification Number)
106	2010BA	NM1	NM109 – Subscriber Primary ID	Use the twelve-digit enrollee ID number assigned by Virginia Medicaid
149	2300	CLM		Note that the HIPAA implementation guides allow only 100 repetitions of the 2300 CLM loop within each patient/subscriber loop.
150	2300	CLM	CLM01 – Claim Submitter’s Identifier	Doral Dental’s claim ID
151	2300	CLM	CLM02 – Total Claim Charges	The total amount charged by the provider for the services on this record.
151	2300	CLM	CLM05-1 – Place of Service	See allowed values in code source 237.
151	2300	CLM	CLM05-3 – Claim Frequency Type Code	Use one of the following codes: 1 – Original Claim 7 – Replacement Claim 8 – Void If the claim contains a value of 7 or 8, please see the ADJUSTMENTS and VOIDS section in the introduction to ensure the records conform to DMAS’s requirements.

Page	Loop	Segment	Data Element	Clarification
153	2300	CLM	CLM11-1 – Related Causes Information	Required if claim was related to: AA – Auto Accident EM – Employment OA – Other Accident
155	2300	CLM	CLM12 – Special Program Code	If the service is rendered under one of the following programs, the appropriate value should be provided: 01 – EPSDT 02 – Physically Handicapped Children's Program 03 – Special Federal Funding 05 – Disability
157	2300	DTP	DTP03 – Related Hospitalization Admission Date	Hospital Admission Date, if applicable
159	2300	DTP	DTP03 – Discharge Date	Hospital Discharge Date, if applicable
180	2300	REF	REF02 – Original Reference Number	If this record is an adjustment to a previously submitted claim (i.e., CLM05-3 = 7 or 8), send claim number being adjusted.
A17	2300	REF	REF02 – Referral or Prior Authorization Number	If a referral or prior authorization was required and the number is not coded at the service line level, code it here.
186	2300	NTE	NTE01 – Note Reference Code	Use "ADD" (Additional Information)
186	2300	NTE	NTE02 – Claim Note Text	If used to report periodontal charting information; see page 185 of the IG for suggested format. This data element can also be used to provide additional explanations, request consultant review, report anesthesia time, or other medical justification which may impact payment.
201	2310B	REF	REF01 – Reference Identification Qualifier	Use "1D" (Medicaid Provider Number). This segment will not be needed after full implementation of the NPI. IN its place the NM1 segment will be used to report the rendering provider NPI.

Page	Loop	Segment	Data Element	Clarification
202	2310B	REF	REF02 – Rendering Provider Secondary ID	This is the nine-digit Medicaid ID assigned by DMAS to the provider rendering the service. This segment will not be needed after full implementation of the NPI.
209	2320	SBR		This loop will be used once by the Dental Administrator and once for each additional payer.
210	2320	SBR	SBR01 – Payer Responsibility Sequence Code	Use "S" (Secondary) or "T" (Tertiary)
210	2320	SBR	SBR02 – Individual Relationship Code	Use "18" (Self)
210	2320	SBR	SBR03 – Group or Policy Number	Use "1076" for Doral Dental
211	2320	SBR	SBR04 – Plan Name	Use "Doral Dental"
216	2320	CAS		If you denied this claim or made any adjustment at the claim level, use the following 2320 segments. If denials or adjustments were made at the service level, use the corresponding 2430 segments.
216	2320	CAS	CAS02, 05, 08, 11, 14, 17 – Adjustment Reason Codes	Use any denial codes in the first segments; if the claim is not denied, use the segments needed to balance the transaction.
216	2320	CAS	CAS03, 06, 09, 12, 16, 18 – Adjustment Amount	If the claim was denied, show the entire charge amount as denied; otherwise use segments as needed to balance the transaction.
220	2320	AMT	AMT02 – Payer Paid Amount	Enter the amount you paid for this claim.
223	2320	AMT	AMT02 – Patient Responsibility Amount	Enter any amount paid by the patient for this claim.
228	2320	DMG	DMG02 – Subscriber's Date of Birth	CCYYMMDD
228	2320	DMG	DMG03 – Subscriber's Gender	Valid values are: F – Female M – Male U – Unknown
241	2330B	NM1	NM103 – Other Payer Name	"Doral Dental"

Page	Loop	Segment	Data Element	Clarification
241	2330B	NM1	NM109 – Other Payer Primary Identifier	Use “1076” for Doral Dental
246	2330B	DTP	DTP03 – Date Claim Paid	The date on which your system paid or adjudicated this claim.
266	2400	SV3	SV301-1 – Service ID Qualifier	Use “AD” (American Dental Association Codes/Current Dental Terminology)
267	2400	SV3	SV301-2 – Procedure Code	Valid CDT (Current Dental Terminology) procedure code
268	2400	SV3	SV302 – Line Charge Amount	Line item charge amount
268	2400	SV3	SV303 – Facility Type Code (Place of Service)	Use any valid value from code source 237
269	2400	SV3	SV304-1 to SV304-5 – Oral Cavity Designation	The only values that DMAS will process are: 00 – Entire oral cavity 10 – Upper right quadrant 20 – Upper left quadrant 30 – Lower right quadrant 40 – Lower left quadrant Other codes identified in the IG will be mapped by First Health if there is a one-to-one correspondence with the codes above.
270	2400	SV3	SV305 – Prosthesis, Crown or Inlay Code	Use “I” for initial placement or “R” for replacement; if “R” is used, the DTP segment for prior placement is required.
270	2400	SV3	SV306 – Procedure Count	Number of procedures
271	2400	TOO	TOO01 – Code List Qualifier	Use “JP” (National Standard Tooth Numbering System)
272	2400	TOO	TOO02 – Tooth Number	If tooth number is applicable to this service line, use a value from code source 135.

Page	Loop	Segment	Data Element	Clarification
272	2400	TOO	TOO03-1 to TOO03-5 – Tooth Surface	Required if the procedure code requires tooth surface codes. Valid codes are: B = Buccal D = Distal F = Facial (or Labial) I = Incisal L = Lingual M = Mesial O = Occlusal
274	2400	DTP	DTP03 – Service Date	Date on which the service was performed
275	2400	DTP	DTP03 – Prior Placement Date	Date on which prior placement was performed (for prosthesis, crown, or inlay that is being replaced)
A33	2400	REF	REF02 – Prior Authorization or Referral Number	Required if a referral or prior authorization was required and the number was not coded at the claim level.
286	2400	REF	REF02 – Line Item Control Number	Line Item Control Number
288	2400	NTE	NTE01 – Note Reference Code	Use "ADD" (Additional Information) if needed
288	2400	NTE	NTE02 – Line Note Text	Line note text – see IG
291	2420A	NM1	NM109 – Rendering Provider ID	After implementation of the NPI, this should contain the NPI for the rendering or servicing provider, if different than the ID reported at the claim level. Prior to NPI, use Employer's Identification Number or Social Security Number.
295	2420A	REF	REF01 – Reference ID Qualifier	Use "1D" (Medicaid Provider Number). This segment will not be needed after full implementation of the NPI. In its place the NM1 segment will be used to report the rendering provider NPI.
296	2420A	REF	REF02 – Rendering Provider Secondary Identifier	This should contain the rendering provider's nine-digit Medicaid ID number, if different from that reported at the claim level. This segment will not be needed after full implementation of the NPI.

Page	Loop	Segment	Data Element	Clarification
	2430			If any adjustments are made at the service line level, this Loop must be used.
302	2430	SVD	SVD02 – Service Line Paid Amount	The amount paid for this service line.
307	2430	CAS	CAS02, 05, 08, 11, 14, 17 – Adjustment Reason Codes	Use any denial codes in the first segments; if the claim is not denied, use the segments needed to balance the transaction.
307	2430	CAS	CAS03, 06, 09, 12, 16, 18 – Adjustment Amount	If the claim was denied, show the entire charge amount as denied; otherwise use segments as needed to balance the transaction.
312	2430	DTP	DTP03 – Line Adjudication Date	Date on which this service line was adjudicated.
B.30		SE	SE01 – Number of Included Segments	Total number of segments included in a transaction set, including the ST and SE segments.
B.30		SE	SE02 – Transaction Set Control Number	Must match the control number in ST02.
B.10		GE	GE01 – Number of Transaction Sets Included	Total number of transaction sets included.
B.10		GE	GE02 – Group Control Number	Must be the same number contained in GS06.
B.7		IEA	IEA01- Number of Included Functional Groups	A count of the number of functional groups included in the interchange.
B.7		IEA	IEA02 – Interchange Control Number	Must match the control number in ISA13.